Form A19-1A (Rev. 5/91)	State of Washington INVOICE VOUCHER

Agency No.	Agency Use Only Location Code	P.R. or Auth. No.
303	GR5	

AGENCY NAME

Washington State Department of Health

DOH-CFH-CWP-WIC-NLS

VENDOR OR CLAIMANT

INSTRUCTIONS TO VENDOR OR CLAIMANT:
Submit this form to claim payment for materials, merchandise or services. Show complete detail for each item.

Vendor's Certificate: I hereby certify under penalty of perjury that the items and totals listed herein are proper charges for materials, merchandise or services furnished to the State of Washington, and that all goods furnished and/or services rendered have been provided without discrimination because of age, sex, marital status, race, creed, color, national origin, handicap, religion, or Vietnam era or disabled veterans status.

By_____

_____
(Title) **(Date)**

Social Security No.	Received by:	Date Received:

I hereby certify that I attended the following training:
Clerk/Certifier ☐ **Nutritionist** ☐ **Coordinator** ☐ **Other** ☐_____

Dates Attended:

I therefore claim the following travel expenses:

# of Breakfasts_____	# of Lunches _____	# of Dinners_____
Meal Allowance $_____	Meal Allowance $_____	Meal Allowance $_____
Total: $_____	Total: $_____	Total: $_____

Meals: .....**$**_____

Lodging: (attach original receipt).....**$**_____

Mileage: (Personal Vehicle only) X $.345 .....**$**_____
(Agency Vehicle –please use separate form)

Other: (describe clearly) _____.....**$**_____

TOTAL: $_____

Prepared by	Telephone Number (360)	Date	Agency Approval	Date

Doc. Date	Pmt Due Date	Current Doc No.	Ref. Doc No.	Vendor Number	Vendor Message	Use Tax	UBI Number

	Master Index					WorkClass	County	City/Town					
Fund	Appn Index	Master Index	Sub Obj	Sub Sub Obj	Org Index	Alloc	Budget Unit	MOS	Project	Sub Proj	Proj Phas	Amount	Invoice Number
	752	11340	EG	4112									

Accounting Approval for Payment	Date	Warrant Total	Warrant Number